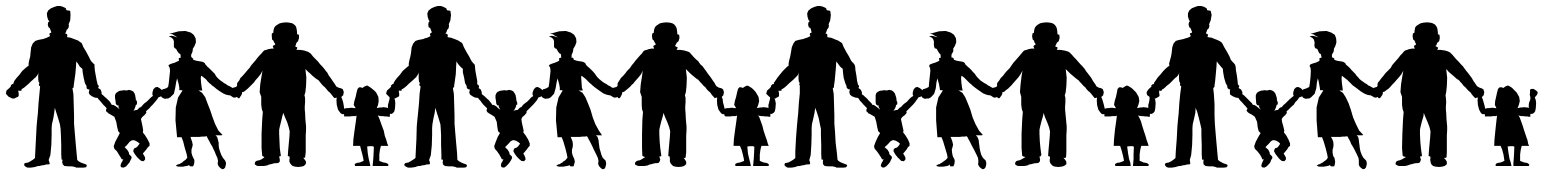
This is the

Annual Individualized Family Service Plan

For _____ and Family

Date _____



The mission of the Arizona Early Intervention Program is to enhance the capacity of families to support their infants and toddlers with delays or disabilities to thrive in their homes and communities.

Child ID #	
Initial AzEIP Referral Date	
AzEIP Eligibility Date	
Initial/Annual IFSP (Circle one) Date	
6 Month Review	
Other Review	

Arizona Early Intervention Program

Child and Family

Child's Name _____ Date of birth _____ Gender _____

First Middle Last

Address _____ City _____ Zip Code _____

Phone _____ County _____ School District _____

Language of the home _____ Language of the Child _____ Interpreter Needed? ____Yes ____ No If yes, what Language? _____

Ethnicity _____ Native American Tribe _____ Reservation _____

Major cross streets or directions to home: _____

Child Resides With (Name) _____ Relationship to child _____

Child's Parents, if different from above:

Name _____ Phone Number _____

_____ _____

Family Members _____ Relationship _____

_____ _____

Surrogate Parent (if needed) _____ Address/Phone Number _____

IPP Team Lead _____ Agency/Program/Phone _____

Service Coordinator Agency/Program/Phone

Arizona Early Intervention Program

HEARING SCREENING TRACKING FORM

Child's Name: DOB: Mother's Maiden Name:

Birth Order (multiples): ☐ A ☐ B ☐ C ☐ D Date: Birthing Hospital:

1. Review of Medical History/Records

Previously Diagnosed Hearing Loss? ☐ Yes ☐ No

Newborn Hearing Screening

In-Patient Results	OAE	Right ☐ Pass ☐ Refer Left ☐ Pass ☐ Refer
	ABR	Right ☐ Pass ☐ Refer Left ☐ Pass ☐ Refer

Outpatient Screen (follow-up from Newborn Screen)

Out-Patient Results	Date:_____	
	OAE	Right ☐ Pass ☐ Refer Left ☐ Pass ☐ Refer
	ABR	Right ☐ Pass ☐ Refer Left ☐ Pass ☐ Refer

Where was screening completed:

Hearing Evaluation ABR

Where was test completed:

Date:	Results:

Recommendations:

Hearing Evaluation Behavior Testing (audiogram)

Where was test completed:

Date:	Results:

Recommendations:

2. Indicators for Children Who are at Risk for Late Onset or Progressive Hearing Losses

Check risk factors that are present:

☐	Parental/ caregiver concern regarding hearing, speech, language, and or developmental delay
☐	Family history of permanent childhood hearing loss.
☐	Postnatal infections associated with sensorineural hearing loss including bacterial meningitis
☐	Head trauma
☐	Recurrent/ persistent otitis media with effusion for at least 3 months
☐	Stigmata/ other findings associated with a syndrome known to include sensorineural/ conductive hearing loss/ Eustachian tube dysfunction.
☐	Syndromes associated with progressive hearing loss such as neurofibromatosis, osteopetrosis and Usher's syndrome.
☐	Neonatal indicators-specifically hyberbilirubinemia at a serum level requiring exchange transfusion, persistent pulmonary hypertension of the newborn associated with mechanical ventilation, and conditions requiring the use of extracorporeal membrane oxygenation (ECHMO.)
☐	Neurodegenerative disorders, such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich's ataxia and Charcot-Marie-Tooth syndrome.
☐	Chemo-therapy

Recommendations:

Guideline For Follow-up Hearing Screening:

- If a child passed a newborn hearing screening within the last 6 months and presents with no risk factors for late-onset or progressive hearing loss, then the child does not need further objective screening for one year.
- If a child does not pass the screening the child should get a follow-up hearing screening within 2-4 weeks. If the child does not pass the follow-up screening, they should receive a medical evaluation of the middle ear and evaluation by a pediatric audiologist to rule out hearing loss.

Results of Hearing Screening

Date: _____ Screener:_____

Visual Inspection Right ☐ Pass ☐ Refer Left ☐ Pass ☐ Refer

☐ OAE ☐ Pure Tone Right ☐ Pass ☐ Refer ☐Could not test Left ☐ Pass ☐ Refer ☐Could not test

☐ Tympanometry Right ☐ Pass ☐ Refer ☐Could not test Left ☐ Pass ☐ Refer ☐Could not test

Recommendations: _____

Rescreen

Date: _____ Screener:_____

Visual Inspection Right ☐ Pass ☐ Refer Left ☐ Pass ☐ Refer

☐ OAE ☐ Pure Tone Right ☐ Pass ☐ Refer ☐Could not test Left ☐ Pass ☐ Refer ☐Could not test

☐ Tympanometry Right ☐ Pass ☐ Refer ☐Could not test Left ☐ Pass ☐ Refer ☐Could not test

Recommendations: _____

Referred to:_____Date:_____

VISION SCREENING CHECKLIST

NOTE TO SCREENERS AND PARENTS:

This screening was developed to use with infants, toddlers and young children who cannot participate in an acuity screening. When a child can match, select, identify or name a picture or symbol that is the same as the one the screener is showing to the child, one of the formal acuity screenings designed for early learners should be given as a supplement to this checklist screening.

CHILD'S NAME: _____ **Screener Agency:** _____

Child's Date of Birth: _____ **Chronological age** (age at the time of the screening): _____

Adjusted age (for prematurely born children now under two years, subtract # of weeks prematurely from the chronological age): _____

Person(s) completing the checklist : 1. *(parent/caregiver)*

2. 3.

(Please write your role on the child's team or your agency after your name) **CHECKLIST COMPLETION DATE:** _____

SCREENER NOTE : Completed screenings with indicators checked require a family copy to share with health care provider.

If your child has not seen an eye doctor yet, completing this screening will give you an indication of possible concerns or signs to watch for.
If your child has already seen an eye doctor, completing this screening will tell more about how your child uses vision.
THERE IS NO SCREENING THAT WILL SUBSTITUTE FOR AN EYE EXAM BY A PEDIATRIC EYE DOCTOR.

Has the child seen an eye doctor (an ophthalmologist, M.D. or an optometrist, O.D.) ? **YES** ☐ **NO** ☐

If yes, DOCTOR'S NAME : _____

DOCTOR'S ADDRESS or PHONE : _____

ADDITIONAL VISION INFORMATION (diagnosis, glasses or other treatment, follow up scheduled or anticipated) :

RISK FACTORS FOR VISION LOSS

These are family and medical history details that have a high incidence of vision loss in infants and toddlers

- ☐ **Family history of eye conditions other than glasses wear or age related cataracts?**
  LIST Family eye condition: _____
- ☐ **Meningitis or encephalitis**
- ☐ **Maternal history of infection during pregnancy** (CMV, toxoplasmosis, rubella, STD)
- ☐ **Premature birth of 36 weeks or less** ***NUMBER OF WEEKS:***
- ☐ **Exposure to oxygen more than 24 hours**
- ☐ **Head trauma episode**
- ☐ **Seizure Disorder**
- ☐ **Birth Weight of less than 3 lbs. (or 1300 grams)** ***BIRTH WEIGHT:***
- ☐ **Neurological Issues**
- ☐ **Significant prenatal exposure to alcohol or drugs including prescription drugs**
- ☐ **A parent/caregiver concern about the way the child uses vision.**

LIST CONCERNS:

***Note:** If your child has identified **RISK FACTORS**, ask your health care provider how the risk factors might affect your child's vision.*

BEHAVIORAL SIGNS THAT MIGHT INDICATE VISION LOSS

These are known ways that young children behave when they are experiencing some difficulty using their vision

- ☐ **Tilts or turns head to one side while looking** (if child is older than 6 months)
- ☐ **Does not notice people or objects when placed in certain areas**
- ☐ **Responds to toys only when there is an accompanying sound** (if child is older than 6 months)
- ☐ **Moves hand or object back and forth in front of eyes** (if child is older than 12 months)
- ☐ **Eyes make constant, quick movements or appear to have a shaking movement** (this is called *nystagmus*)
- ☐ **Squints, frowns or scowls when looking at objects**
- ☐ **Consistently over or under reaches** (if child is older than 6 months)
- ☐ **Cannot see a dropped toy** (if child is older than 6 months)
- ☐ **Brings objects to one eye rather than using both eyes to view**
- ☐ **Covers or closes one eye frequently**
- ☐ **Eyes appear to turn inward, outward, upward, or downward** (if child is older than 6 months)
- ☐ **Places an object within a few inches of eyes to look** (if child is older than 12 months)
- ☐ **Trips on curbs or steps** (if child is older than 18 months)
- ☐ **Thrusts head forward or backward when looking at objects**
- ☐ **Eye poking, rocking, staring at bright lights frequently**

***Note:** If your child has identified **BEHAVIORIAL SIGNS**, send a copy of the completed checklist to your child's health care provider and ask to discuss referring your child to a pediatric eye doctor.*

☐ **No indicators are checked. Further attention to vision is not indicated at this time.**

☐ **One or more risk factors have been identified. Copy to family for risk factor discussion with family health care provider.**

☐ **One or more behavioral signs have been identified. Copy to family for their health care provider to review for health care system referral to a *pediatric eye doctor* for a complete eye exam.**

A checklist screening is a general indicator. Not every child with a screening checkmark will have a vision problem. Some children without a checkmark will still have a vision problem that was not consistent enough to show up when the checklist was completed. If your child begins to show signs of poor vision use or if there is a significant change in vision, contact your child's health care provider. **REQUIRED Signature (*person completing this form with parent/caregiver*):** _____

Family Resources, Priorities, Concerns and Interests

Related to Our Child's Development

We'd like to know more about you and your family so that we can support you in helping your child learn and grow. There are many areas we can talk about; some examples are listed here. You may choose not to talk about any of these things with us at this time.

- What I want most for my child and family…..*Now or in the future*
- What I feel most confident about as a parent….
- Questions I have about my child's development or abilities to participate in everyday activities, such as *enjoying taking a bottle or breastfeeding; calming himself so he can sleep, letting us know what he wants, being able to move around in the apartment.*
- Family and community resources that help our family…*Resources can be informal, for example friends, family, neighbors and church members. Formal resources include social service programs, education programs, and other professionals.*
- Family and community resources that we are interested in to help our family (such as WIC, health care, learning more about my child's future development)
- Future activities that our family is interested in planning *(for example family trip, household move, library story time, attending baseball games)* and wonder how our child can fully participate

Date:

Natural Learning Opportunities
Everyday Family Activities, Settings, and Interactions

Children learn and grow every day. Children learn through play, through interacting with others, and through everyday routines like bedtime, mealtime and play. Your child's developmental strengths and difficulties are reflected in daily routines and interactions.

- How does your family spend the day?
- Where and with whom does your child spend time?
- Which people, toys, activities, routines and places interest your child most and/or frustrate your child most?
- What activities, routines, and places interest your family?

Date:

Health and Medical Status

Tell us about your child's health. Include health concerns, new diagnoses, serious illnesses or accidents, seizures, hospitalizations, and medications taken regularly.

Date:

Doctors and Others Providing Health Care for your Child

Primary Care Provider (PCP):		Address/Phone	
Others, include specialty			

Health Insurance Co/Plan		Group #		Effective Date of Coverage	
Name of Insured		Insured ID #			

Is your child Arizona Long Term Care (ALTCS) Eligible? Y N ALTCS Health Plan

Summary of Child's Present Levels of Development

To help us plan how to provide you and your child with supports and services, we prepare a summary of your child's health, growth and development. You have already helped us gather this information. Possible sources of information for this summary include conversations we have had with you, observations of your child in daily routines, formal evaluation and assessments and medical reports.

Areas for us to think about in the context of family's routines and activities include the child's ability to learn and use new skills, engage in relationships with others, and be independent within family routines. The areas of development that emerge in this description of the child include physical development including vision and hearing, fine and gross motor skills, adaptive abilities, social-emotional skills, communication and cognitive development.

Date:

Summary of Child's Present Levels of Development, continued

This page may be used as a continuation of the previous page, or to record an update at the time of a review.

Date:

Functional Outcome for Child and Family

Outcome #

What does your family want to see happen?
What is happening now related to this outcome?
What strategies will we work together on towards this outcome? Include activity settings, people, and everyday routines of the child and family.
How will we know we have made progress?

Outcome status: *We as a team have reviewed this outcome and have decided (date any that apply)….*	This is a new outcome:	Date:	We have completed or reached this outcome:	**Date:**
	We will continue this outcome:	Date:	We have revised this outcome:	Date:
	We will discontinue this outcome:	Date:		

Justification of Early Intervention Outcomes That Cannot Be Achieved Satisfactorily In A Natural Environment

Outcome #	Service	Location of Service	Name of Service Provider

Explain how and why the outcome(s) could not be met if the service was provided in natural environments. If there has not been satisfactory progress towards an outcome in a natural environment, include a description of why alternative natural environments have not been selected or the outcome has not been modified.

Explain how services provided in this location may be generalized within activity settings and routines of the family.

Describe a plan with timelines and supports necessary to allow the outcome(s) to be satisfactorily achieved in natural environments.

Transition Plan and Timeline

Activities	Steps	Timeline	Date(s) Achieved
Parents informed of programs and services available after a child's third birthday.	Service Coordinator begins to share information about transition from early intervention at age three.	Throughout enrollment in AzEIP.	
With parent consent, records are shared with the School District.	Service Coordinator discusses with parent consent and with consent, sends current records to the school district.	Prior to Transition Planning Conference.	
Complete Comprehensive Developmental Assessment, including update of vision & hearing screening	Service Coordinator works with team to ensure that comprehensive developmental assessment is up to date.	At or before the Transition Planning Conference.	
Transition Planning Conference	Using the Invitation to Participate, Part I of the Transition Planning Conference Summary form, Service Coordinator arranges and invites school district representative to the Transition Planning Conference at least two weeks prior to the conference.	2.3 years – 2.9 years	
Transition Conference Summary.	Service Coordinator documents people, events and timelines agreed upon at the meeting using Part II of the Transition Planning Conference Summary and shares copies with the IFSP team members.	During Planning Conference.	
Attend Preschool Eligibility Conference/ Multidisciplinary Evaluation Team Conference.	Service Coordinator and provider from IFSP team provide information to assist with determining eligibility for preschool special education services.	By your child's 3rd birthday.	
If program other than special education and related services is chosen by family, referral made to appropriate community program(s).	Other referrals may also be made at this time, but procedures may vary. Service Coordinator and family may release records to selected program(s).	By time of exit from early intervention or your child's 3rd birthday.	
Attend Individualized Education Plan (IEP)Meeting.	Service Coordinator and provider from the IFSP team attend IEP meeting.	By your child's 3rd birthday.	
Other steps to be taken to ensure a successful transition from early intervention:	Service Coordinator may facilitate visit to community preschools, Head Start or YMCA programs and/or provide information about other resources.	By your child's 3rd birthday.	

Supports and Services Needed to Make Progress Toward Outcomes

Supports/Services *Each service and support must be linked to an outcome.*	Outcome #	Who will do this?	How often and how long each time? (Frequency)	In what activity setting will this take place?	Who will pay?	Planned Start Date	Actual Start Date	Planned End Date	Actual End Date
Service Coordination									
Other Services Needed	Steps Taken to Secure Service								
Other Services in Place	Notes/Comments								

IFSP Team

Informed Consent by Parent(s) for Early Intervention Services				
I have participated in the development of this IFSP and understand the content. I understand that I can accept or refuse any or all of the services identified on the IFSP. I understand that my consent for services may be withdrawn at any time. **Please initial and sign below.**				
	Initial/ Annual	**6 month**	**Other**	
1				I agree with the proposed IFSP as written. I further understand that my signature below indicates that: (a) I have been fully informed of the supports/services being proposed; (b) my Service Coordinator explained my rights under this program and I received a written copy of the AzEIP Procedural Safeguards for Families Booklet; and (c) I give permission to carry out this IFSP as written.
2				I do not agree with the proposed IFSP as written. My service coordinator explained my rights under this program, and I received a written copy of the AzEIP Procedural Safeguards for Families Booklet. [**Notice of Action must be given to the family.]** However, I do give permission for the following supports/services to begin (list here):
3.		I have received a copy of the AzEIP Family Survey (**Annual IFSP only**.)		

Parent/Surrogate Signature
Initial/Annual _____ Date _____

Parent/Surrogate Signature
6 month _____ Date _____

Parent/Surrogate Signature
Other _____ Date _____

Date(s) this IFSP was revised with a meeting				

Note: Parent must indicate approval for changes made to the IFSP by initialing and dating the changes (unless per phone request by parent.)

List IFSP Team Members, present or not, who have contributed to the development of this IFSP, using additional page if needed.

			Date Present	Date Report given
Service Coordinator	Agency/Program	Phone		
Team Lead/Member	Agency/Program	Phone		
Team Member	Agency/Program	Phone		

IFSP Team , continued

			Date Present	Date Report given
Team Member/Relationship	Agency/Program	Phone		
Team Member/Relationship	Agency/Program	Phone		
Team member/Relationship	/Agency/Program	Phone		

In addition to the release of this IFSP to team members, I give my consent for copies of this IFSP to be released to the individuals or agencies listed below:

Date	Name	For the purpose of: (information, collaboration, etc)
Parent/Surrogate Signature		Date
Parent/Surrogate Signature		Date
Parent/Surrogate Signature		Date